FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042416

Facility Name: PLEASANT VIEW

Address: 500 NORTH JACKSON (Number) MORRISON (City) 61270 (Zip Code)

County: WHITESIDE

Telephone Number: 815 772-7288 **Fax #** 815 772-2399

IDPA ID Number: 362819435003

Date of Initial License for Current Owners:

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: ALAN GAPINSKI **Telephone Number:** 815 778-3683

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01-01-01 to 12-31-01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) ALAN GAPINSKI
(Title) PRESIDENT

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 01-01-01 Ending: 12-31-01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 74

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	74	Intermediate (ICF)	74	27,010	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	17,191	8,753		25,944	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,191	8,753		25,944	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.05%

D. How many bed-hold days during this year were paid by Public Aid?
112 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location
Date started 12/6/1996

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/6/1996 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified ____ and days of care provided ____

Medicare Intermediary ____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basi

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 01-01-01 Ending: 12-31-01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	156,124	16,751	4,893	177,768	366	178,134		178,134			1
2	Food Purchase		131,088		131,088		131,088	(2,621)	128,467			2
3	Housekeeping	42,041	14,296		56,337	147	56,484		56,484			3
4	Laundry	42,825	15,139		57,964	110	58,074		58,074			4
5	Heat and Other Utilities			62,733	62,733		62,733	(3,835)	58,898			5
6	Maintenance	53,279	19,801	18,345	91,425		91,425		91,425			6
7	Other (specify):*											7
8	TOTAL General Services	294,269	197,075	85,971	577,315	623	577,938	(6,456)	571,482			8
	B. Health Care and Programs											
9	Medical Director			2,750	2,750		2,750		2,750			9
10	Nursing and Medical Records	748,471	45,518	17,502	811,491	(10,655)	800,836		800,836			10
10a	Therapy	23,949		2,642	26,591		26,591		26,591			10a
11	Activities	55,399	4,704		60,103		60,103		60,103			11
12	Social Services	55,293		141	55,434		55,434		55,434			12
13	Nurse Aide Training			2,635	2,635	11,607	14,242		14,242			13
14	Program Transportation		2,592		2,592	(1,033)	1,559		1,559			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	883,112	52,814	25,670	961,596	(81)	961,515		961,515			16
	C. General Administration											
17	Administrative			112,577	112,577		112,577	(7,666)	104,911			17
18	Directors Fees											18
19	Professional Services			8,023	8,023		8,023	1,746	9,769			19
20	Dues, Fees, Subscriptions & Promotion			21,885	21,885		21,885	(6,961)	14,924			20
21	Clerical & General Office Expenses	38,086	6,924	17,333	62,343		62,343	1,732	64,075			21
22	Employee Benefits & Payroll Taxes			218,732	218,732	(1,575)	217,157		217,157			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,055	6,055		6,055	120	6,175			24
25	Other Admin. Staff Transportation							747	747			25
26	Insurance-Prop.Liab.Malpractice			26,783	26,783		26,783	116	26,899			26
27	Other (specify):* SALES TAX			621	621		621	13,791	14,412			27
28	TOTAL General Administration	38,086	6,924	412,009	457,019	(1,575)	455,444	3,625	459,069			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,215,467	256,813	523,650	1,995,930	(1,033)	1,994,897	(2,831)	1,992,066			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PLEASANT VIEW #0042416 Report Period Beginning: 01-01-01 Ending: 12-31-01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			39,364	39,364		39,364	66,905	106,269			30
31	Amortization of Pre-Op. & Org											31
32	Interest			43,246	43,246		43,246	104,098	147,344			32
33	Real Estate Taxes			25,539	25,539		25,539		25,539			33
34	Rent-Facility & Grounds			155,697	155,697		155,697	(155,697)				34
35	Rent-Equipment & Vehicles			6,000	6,000		6,000		6,000			35
36	Other (specify):* GOODWILL			11,316	11,316		11,316	(11,316)				36
37	**TOTAL Ownership**			281,162	281,162		281,162	3,990	285,152			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					1,033	1,033		1,033			38
39	Ancillary Service Centers		9,911		9,911		9,911		9,911			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,404	40,404		40,404		40,404			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		9,911	40,404	50,315	1,033	51,348		51,348			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,215,467	266,724	845,216	2,327,407		2,327,407	1,159	2,328,566			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 01-01-01 Ending: 12-31-01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals	(2,621)	2		4
5	Telephone, TV & Radio in Resident Room	(3,835)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	13,033	30		9
10	Interest and Other Investment Incom				10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salar				12
13	Sales Tax	(621)	27		13
14	Non-Care Related Interes				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona	(6,370)	20		25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising	(420)	20		28
29	Other-Attach Schedule SEE ATTACHED	(11,678)	21,36		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (12,512)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organizatio Costs (Schedule VII)	14,091		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 14,091		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,579		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport	X		$ 1,033	14,38	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,033		47

PLEASANT VIEW

ID# 0042416

Report Period Beginning: 01-01-01

Ending: 12-31-01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Goodwill	$ 11,316	36	1
2	Flowers	362	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	11,678		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PLEASANT VIEW # 0042416 **Report Period Beginning:** 01-01-01 **Ending:** 12-31-01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,621)	0	0	0	0	0	0	0	0	0	0	(2,621)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(3,835)	0	0	0	0	0	0	0	0	0	0	(3,835)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,456)	0	0	0	0	0	0	0	0	0	0	(6,456)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	104,911	(112,577)	0	0	0	0	0	0	0	(7,666)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	1,746	0	0	0	0	0	0	0	0	1,746	19
20	Fees, Subscriptions & Promotions	(6,790)	0	249	(420)	0	0	0	0	0	0	0	(6,961)	20
21	Clerical & General Office Expenses	(362)	0	2,094	0	0	0	0	0	0	0	0	1,732	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	120	0	0	0	0	0	0	0	0	120	24
25	Other Admin. Staff Transportation	0	0	747	0	0	0	0	0	0	0	0	747	25
26	Insurance-Prop.Liab.Malpractice	0	0	116	0	0	0	0	0	0	0	0	116	26
27	Other (specify):*	(621)	0	14,412	0	0	0	0	0	0	0	0	13,791	27
28	**TOTAL General Administration**	(7,773)	0	124,395	(112,997)	0	0	0	0	0	0	0	3,625	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,229)	0	124,395	(112,997)	0	0	0	0	0	0	0	(2,831)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PLEASANT VIEW # 0042416 **Report Period Beginning:** 01-01-01 **Ending:** 12-31-01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	13,033	51,249	2,623	0	0	0	0	0	0	0	0	66,905	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	101,178	2,920	0	0	0	0	0	0	0	0	104,098	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(155,697)	0	0	0	0	0	0	0	0	0	(155,697)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):* GOODWILL	(11,316)	0	0	0	0	0	0	0	0	0	0	(11,316)	36
37	TOTAL Ownership	1,717	(3,270)	5,543	0	0	0	0	0	0	0	0	3,990	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(12,512)	(3,270)	129,938	(112,997)	0	0	0	0	0	0	0	1,159	45

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 01-01-01 Ending: 12-31-01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BIG MEADOWS , INC.	100.00%	BIG MEADOWS, INC.	SAVANNA			
AMERICAN HEALTH ENTERPRISES, INC	100.00%					
ALAN GAPINSKI	100.00%					
	0.00%	WINNING WHEELS, INC.	PROPHETSTOWN			
	0.00%	STRIVE	PROPHETSTOWN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organizatior	6 Percent of Ownership	7 Operating Cost of Related Organizatior	8 Difference: Adjustments for Related Organizatior Costs (7 minus 4)	
1	V	34	RENT	$ 155,697	OSO PARTNERS - OWNERS OF BUILDING	100.00%	$	$ (155,697)	1
2	V	30	DEPRECIATION				51,249	51,249	2
3	V	32	MORTGAGE INTEREST				101,178	101,178	3
4	V	17	PROFESSIONAL SERVICES	112,577	AMERICAN HEALTH ENTERPRISES (OPERATION)	100.00%	129,938	17,361	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 268,274			$ 282,365	$ * 14,091	14

* Total must agree with the amount recorded on line 34 of Schedule VI

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 01-01-01 Ending: 12-31-01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	AMERICAN HEALTH ENTERPRISES, INC.								$		1
2			DIRECT								2
3	ALAN GAPINSKI	PRESIDENT	MANAGEMENT	100.00							3
4											4
5	BIG MEADOWS, INC.			100.00	20,730	10	20.00	MANAGEMENT	123,673	N/A	5
6	PLEASANT VIEW			100.00	20,730	10	20.00	FEES	112,577	17,3	6
7	WINNING WHEELS, INC.			0.00	33,170	16	32.00		216,000	N/A	7
8	S.T.R.I.V.E.			0.00	16,585	8	16.00		102,000	N/A	8
9	OTHERS (NON-COST REPORTING)			0.00	12,440	6	12.00		118,330	N/A	9
10											10
11											11
12											12
13								TOTAL	$ 672,580		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 01-01-01 Ending: 12-31-01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi
or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization AMERICAN HEALTH ENTERPRISES, INC.
Street Address 501 6TH AVE. WEST
City / State / Zip Code LYNDON, IL 61261
Phone Number (815-778-3683
Fax Number (815-778-4503

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	DIRECT COST	1	1	$ 42,615	$ 42,615	1	$ 42,615	1
2	17	ADMINISTRATIVE	GROSS REVENUE	10,444,000	5	252,152	252,152	2,343,000	56,568	2
3	17	ADMINISTRATIVE	DIRECT COST	1	1	1,923	1,923	1	1,923	3
4	17	ADMINISTRATIVE	GROSS REVENUE	10,444,000	5	16,959	16,959	2,343,000	3,805	4
5	19	DATA PROCESSING	GROSS REVENUE	10,444,000	5	6,368	0	2,343,000	1,429	5
6	20	DUES, FEES, SUBSCRIPTIONS	GROSS REVENUE	10,444,000	5	1,108	0	2,343,000	249	6
7	21	SUPPLIES, PHONE	GROSS REVENUE	10,444,000	5	9,334	0	2,343,000	2,094	7
8	19	ACCOUNTING	GROSS REVENUE	10,444,000	5	1,414	0	2,343,000	317	8
9	24	TRAINING, SEMINARS	GROSS REVENUE	10,444,000	5	537	0	2,343,000	120	9
10	26	INSURANCE	GROSS REVENUE	10,444,000	5	516	0	2,343,000	116	10
11	27	BENEFITS	% SALARY	483,938	5	70,379	0	99,097	14,412	11
12	25	ADMIN. TRANSPORTATION	GROSS REVENUE	10,444,000	5	3,332	0	2,343,000	747	12
13	30	DEPR'N VEHICLES	GROSS REVENUE	10,444,000	5	6,892	0	2,343,000	1,546	13
14	30	DEPR'N EQUIPMENT	GROSS REVENUE	10,444,000	5	4,799	0	2,343,000	1,077	14
15	32	INTEREST VEHICLES	GROSS REVENUE	10,444,000	5	3,146	0	2,343,000	706	15
16	32	INTEREST (WORKING CAP)	DIRECT COST	2	2	4,428	0	1	2,214	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 425,902	$ 313,649		$ 129,938	25

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 01-01-01 Ending: 12-31-01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MORTGAGE SEE SCH VII B		X	MORTGAGE	$11,591.00	12/1996	$ 1,350,000	$ 1,187,700		8.3500	$ 101,178	1
2												2
3												3
4												4
5	AMCORE BANK		X	VEHICLES	$624.50	1/2001	30,000	24,856	1/2006	9.0000	706	5
	Working Capital											
6	FIRST IL NATIOANAL BANK		X	WORKING CAPITAL	$7,644.00			345,365		VARIABLE	31,715	6
7	CORPORATE ALLOCATION	X		WORKING CAPITAL			25,000	23,370		9.0000	2,214	7
8	OSO PARTNERS	X		WORKING CAPITAL	$1,636.00		167,700	133,395		8.0000	11,531	8
9	TOTAL Facility Related				$21,495.50		$ 1,572,700	$ 1,714,686			$ 147,344	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,572,700	$ 1,714,686			$ 147,344	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 01-01-01 Ending: 12-31-01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report	$ 37,820	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 26,195	2
3. Under or (over) accrual (line 2 minus line 1).		$ (11,625)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 37,164	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru		$ 25,539	7

Real Estate Tax History

Real Estate Tax Bill for Calendar Year:		
1996		8
1997	27,242	9
1998	26,479	10
1999	25,259	11
2000	26,195	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PLEASANT VIEW COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0042416

CONTACT PERSON REGARDING THIS REPORT ALAN GAPINSKI

TELEPHONE 815-778-3692 FAX #: 815-778-4503

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	00026326	PT NW SEC 17 TWP 21	$ 26,194.56	$ 26,194.56
2.		RNG 5 MF 10831-96	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 26,194.56	$ 26,194.56

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 01-01-01 Ending: 12-31-01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,743 B. General Construction Type: Exterior BRICK Frame METAL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization [ ] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY GROUNDS		1996	$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 01-01-01 Ending: 12-31-01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		1996	1996	$ 1,200,000	$ 30,768	39	$ 30,768	$	$ 153,840	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BOOSTER HEATER			1997	1,582	79	20	79		395	9
10	GARAGE/STORAGE			1997	1,670	84	20	84		418	10
11	BUILT IN WHIRLPOOL BATHING SYSTEMS			1997	22,217	2,222	10	2,222		10,404	11
12	CIRCULATING PUMP			1997	1,353	135	10	135		1,150	12
13	FLOOR TILE			1997	1,430	95	15	95		453	13
14	REMODEL OFFICE			1997	8,092	809	10	809		3,641	14
15	FURNACES			1997	16,130	1,075	15	1,075		5,018	15
16	ROOM SIGNAGE			1997	1,666	167	10	167		750	16
17	PAINTING			1997	12,962	1,852	7	1,852		8,333	17
18	LOCKS & PLATE FLAQUES			1997	820	82	10	82		369	18
19	WINDOW TREATMENTS			1997	772	154	5	154		695	19
20	WINDOW TREATMENTS			1997	5,228	523	10	523		2,353	20
21	DOOR ALARM SYSTEM			1997	12,550	1,255	10	1,255		5,647	21
22	LANDSCAPING			1997	13,055	1,306	10	1,306		5,875	22
23	SEALING PARKING LOT			1997	2,926	585	5	585		2,634	23
24	OFFICE REMODELING (ADDT)			1998	6,367	910	7	910		3,563	24
25	BEAUTY SHOP REMODELING			1998	6,844	342	20	342		1,283	25
26	AIR CONDITIONING/HEATING UNITS			1998	6,332	422	15	422		1,337	26
27	SPRINKLER SYSTEM			1999	10,944	730	15	730		2,128	27
28	POLYVINYL FENCING			1999	2,133	142	15	142		367	28
29	GAZEBO			1999	7,383	492	15	492		1,231	29
30	REMODEL DINING ROOM			1999	20,459	1,023	20	1,023		2,131	30
31	INSTALL LIGHTS & CEILING FANS (NURSING STATION)			2000	989	49	20	49		95	31
32	65 GALLON WATER HEATER			2000	4,696	470	10	470		704	32
33	PLANTER INSTALLATION			2000	3,280	328	10	328		492	33
34	KITCHEN TILE REMODELING			2001	13,860	924	15	924		924	34
35	FURNISH & INSTALL AWNING			2001	2,504	125	10	125		125	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 01-01-01 Ending: 12-31-01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CHANGE A/C COMPRESSOR	2001	$ 2,268	$ 113	10	$ 113	$	$ 113	37
38	REMODEL LAUNDRY ROOM	2001	4,714	30	39	30		30	38
39	HEAT TAPE GUTTERS	2001	1,603	80	10	80		80	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,396,829	$ 47,371		$ 47,371	$	$ 216,578	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe PLEASANT VIEW # 0042416 Report Period Beginning: 01-01-01 Ending: 12-31-01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 383,282	$ 41,105	$ 54,138	$ 13,033	VARIOUS	$ 212,251	71
72	Current Year Purchases	30,606	2,137	2,137		VARIOUS	2,137	72
73	Fully Depreciated Assets							73
74	HOME OFFICE ALLOCATION		1,077	1,077				74
75	TOTALS	$ 413,888	$ 44,319	$ 57,352	$ 13,033		$ 214,388	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HOME OFFICE ALLOCATION			$	$ 1,546	$ 1,546	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$ 1,546	$ 1,546	$		$	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,860,717	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 93,236	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 106,269	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,033	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 430,966	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progres

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 01-01-01 Ending: 12-31-01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: OSO PARTNERS
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1974	74	01/01/98	$ 155,697	5	15	3
4	Additions							4
5								5
6								6
7	TOTAL		74		$ 155,697 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: 2002, $1,325,000 *

10. Effective dates of current rental agreement:
    Beginning 01/01/98
    Ending 12/31/02

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/02	$ 155,697
13.	12/31/03	$ 155,697
14.	12/31/04	$ 155,697

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	TRANSPORTATION	1996 VAN	$ 500.00	$ 6,000	17
18					18
19					19
20					20
21	TOTAL		$ 500.00	$ 6,000	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 01-01-01 Ending: 12-31-01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facilit

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training wa not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 96

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 48

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies			330	330
3	Classroom Wages (a)	1,498	6,739		8,237
4	Clinical Wages (b)		3,370		3,370
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments			2,305	2,305
8	Nurse Aide Competency Tests				
9	TOTALS	$ 1,498	$ 10,109	$ 2,635	$ 14,242
10	SUM OF line 9, col. 1 and 2 (e)	$ 11,607			

C. CONTRACTUAL INCOME

In the box below record the amount of income you facility received training aides from other facilities

$ NONE

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	11

(a) Include wages paid during the classroom portion of training. Do not include fringe benefit
(b) Include wages paid during the clinical portion of training. Do not include fringe benefit
(c) For in-house training programs only. Do not include fringe benefit
(d) Allocate based on if the aide is from your facility or is being contracted to be trained i your facility. Drop-out costs can only be for costs incurred by your own aides
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8
(f) Attach a schedule of the facility names and addresse of those facilities for which you trained aides

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be lis on this schedule.

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 01-01-01 Ending: 12-31-01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12-31-01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 70,353	$ 136,225	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 26,000)	314,899	569,089	3
4	Supply Inventory (priced at COST)	30,709	77,343	4
5	Short-Term Investments			5
6	Prepaid Insurance	4,396	12,682	6
7	Other Prepaid Expenses	4,183	15,659	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): SEE ATTACHED		4,837	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 424,540	$ 815,835	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	196,829	198,011	15
16	Equipment, at Historical Cost	179,288	817,748	16
17	Accumulated Depreciation (book methods)	(124,018)	(603,975)	17
18	Deferred Charges	112,422	112,422	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 364,521	$ 524,206	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 789,061	$ 1,340,041	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 155,830	$ 331,659	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	65,000	75,380	29
30	Accrued Salaries Payable	65,993	140,742	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,489	34,432	31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,164	76,347	32
33	Accrued Interest Payable	3,020	4,596	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	OTHER SEE ATTACHED	156,113	3,042	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 498,609	$ 666,198	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	284,016	412,393	39
40	Mortgage Payable	129,744	327,133	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			3,006	43
44	OTHER SEE ATTACHED	129,748	131,883	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 543,508	$ 874,415	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,042,117	$ 1,540,613	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (253,056)	$ (200,572)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 789,061	$ 1,340,041	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (309,144)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (309,144)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	56,088	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 56,088	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (253,056)	24	*

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 2,349,426	1
2	Discounts and Allowances for all Level	(6,000)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,343,426	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,949	6
7	Oxygen	16,732	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 26,681	8
	C. Other Operating Revenue		
9	Payments for Educatior	1,212	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement	3,729	11
12	Gift and Coffee Shop	189	12
13	Barber and Beauty Care	600	13
14	Non-Patient Meals	2,621	14
15	Telephone, Television and Radic	3,835	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 12,186	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	1,202	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,202	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,383,495	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	577,315	31
32	Health Care	961,596	32
33	General Administratior	457,019	33
	B. Capital Expense		
34	Ownership	281,162	34
	C. Ancillary Expense		
35	Special Cost Centers	9,911	35
36	Provider Participation Fee	40,404	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,327,407	40
41	**Income before Income Taxes (line 30 minus line 40)****	56,088	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 56,088	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,962	2,157	$ 47,791	$ 22.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,058	13,635	216,701	15.89	3
4	Licensed Practical Nurses	5,264	5,744	79,106	13.77	4
5	Nurse Aides & Orderlies	40,180	43,324	383,835	8.86	5
6	Nurse Aide Trainees	1,488	1,488	11,607	7.80	6
7	Licensed Therapist	1,858	2,108	23,949	11.36	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,032	2,267	29,942	13.21	9
10	Activity Assistants	1,947	2,278	25,457	11.18	10
11	Social Service Worker	4,066	4,700	55,292	11.76	11
12	Dietician					12
13	Food Service Supervisor	1,962	2,122	22,561	10.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,162	20,363	133,563	6.56	15
16	Dishwashers					16
17	Maintenance Worker	5,046	5,592	53,279	9.53	17
18	Housekeepers	6,999	7,529	42,040	5.58	18
19	Laundry	6,701	7,289	42,825	5.88	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,867	2,114	22,850	10.81	23
24	Clerical	1,978	2,082	15,236	7.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	904	964	9,433	9.79	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	114,474	125,756	$ 1,215,467 *	$ 9.67	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	98	$ 4,893	1/3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	16	819	10/3	39
40	Physical Therapy Consultant	33	1,655	10a/3	40
41	Occupational Therapy Consultan	2	88	10a/3	41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant	2	100	10a/3	43
44	Activity Consultant				44
45	Social Service Consultant	3	141	12/3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	154	$ 7,696		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	550	16,503	10/3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	550	$ 16,503		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			$

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 112,577
TOTAL (agree to Schedule V, line 17, col. 3)	$ 112,577
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
JANIS CARD CO. CPA'S	ACCOUNTING	$ 500
BENEFIT PLANNING CONSULT	PENSION PLAN ADMIN.	790
WARD, MURRAY,PACE,JOHNSO	LEGAL	256
HUSCH & EPPENBERGER	LEGAL	308
ACHIEVE SOFTWARE CORP.	SOFTWARE MAINTENANCE	3,371
CREATIVE SOLUTIONS	MEDICAL RECORDS	1,895
MIDWEST	TIMECLOCK SOFTWARE	525
COMPUTER INTEGRATION	INTERNET ACCESS	378
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 8,023

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,748
Unemployment Compensation Insurance	14,798
FICA Taxes	89,603
Employee Health Insurance	46,458
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
DISABILITY INSURANCE	13,285
LIFE INSURANCE	2,347
401 K	2,169
PHYSICALS	1,428
EMPLOYEE RECOGNITION EVENTS &	
CHRISTMAS GIFTS	7,321
TOTAL (agree to Schedule V, line 22, col.8)	$ 217,157

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,182
Health Care Worker Background Check	210
(Indicate # of checks performed 21)	
DUES & SUBSCRIPTIONS	6,123
ADVERTISING	6,370
CORPORATE ALLOCATION	249
Less: Public Relations Expense	( )
Non-allowable advertising	(6,370)
Yellow page advertising	(420)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,344

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
LISTING ATTACHED	6,055
HOME OFFICE ALLOCATION	120
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,175

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 01-01-01 Ending: 12-31-01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **NO**

(2) Are there any dues to nursing home associations included on the cost repor **YES**
If YES, give association name and amount **ILLINOIS HEALTHCARE ASSOC. $4224**

(3) Did the nursing home make political contributions or payments to a politic
action organization? **NO** If YES, have these cost
been properly adjusted out of the cost report

(4) Does the bed capacity of the building differ from the number of beds licensed at t
end of the fiscal year **NO** If YES, what is the capacity

(5) Have you properly capitalized all major repairs and equipment purchases **YES**
What was the average life used for new equipment added during this perio **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expen
and the location of this expense on Sch. V. **8,183** Line **10**

(7) Have all costs reported on this form been determined using accounting procedur
consistent with prior reports **YES** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangement **NO**
If YES, give effective date of leas

(9) Are you presently operating under a sublease agreement YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f
Schedule VII)? YES NO **X** If YES, please indicate name of the facility
IDPH license number of this related party and the date the present owners took ov

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme
of Public Aid during this cost report period. **40,404**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule
for an individual employee **NO** If YES, attach an explanation of the allocation

(13) Have costs for all supplies and services which are of the type that can be billed
the Department of Public Aid, in addition to the daily rate, been properly classifi
in the Ancillary Section of Schedule V **YES**

(14) Is a portion of the building used for any function other than long term care services f
the patient census listed on page 2, Section B **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac
a schedule which explains how all related costs were allocated to these functior

(15) Indicate the cost of employee meals that has been reclassified to employee benef
on Schedule V. $ **NONE** Has any meal income been offset agains
related costs? **YES** Indicate the amount $ **2,621**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **NO**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation f
residents? **NO** If YES, please indicate the amount of income earned from such
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patient **100%**
d. Have vehicle usage logs been maintained **YES**
e. Are all vehicles stored at the nursing home during the night and all oth
times when not in use **YES**
f. Has the cost for commuting or other personal use of autos been adjust
out of the cost report **YES**
g. Does the facility transport residents to and from day training NO
Indicate the amount of income earned from providing suc
transportation during this reporting period $ NONE

(17) Has an audit been performed by an independent certified public accounting firm **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this co
been attached? If no, please explain

(18) Have all costs which do not relate to the provision of long term care been adjusted o
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic
performed been attached to this cost report **N/A**
Attach invoices and a summary of services for all architect and appraisal fee